Chiropractic Preceptor License Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Chiropractic Commission
P.O. Box 47858
Olympia, WA 98504-7858

Contact us:

360-236-2822

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Washington State Department of Health

Application Instructions Checklist

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

Preceptor Information: Enter your current chiropractic license number, the chiropractic college that you are being approved as a preceptor, the anticipated start and end date of your preceptorship, name and date of birth of the student you are providing direct supervision to, and whether they are a clinical postgraduate trainee or a regular senior student as defined in **WAC 246-808-510**.

☐ **2. Malpractice Insurance:**
Attach proof of malpractice insurance. You must provide evidence of malpractice insurance for the clinical postgraduate trainee, the preceptor applicant and the regular senior student. See **WAC 246-808-190**

☐ **3. Proof of Licensure Attestation:**
Sign and date stating that you have been licensed as a Washington chiropractic doctor for the last five years. During this time my license has not been suspended, revoked, or otherwise conditioned or restricted.

☐ **4. Verification of Approval:**
Attach verification of approval to participate in the program by an approved chiropractic college.

☐ **5. Applicant's Attestation:**
You must sign and date this for us to process the application.

Washington State Department of Health

Date Stamp Here

Revenue: 0252020000

Chiropractic Preceptor License Application

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

Washington State Chiropractic License #	Chiropractic College

Beginning date of preceptorship	Ending date of preceptorship

Student Name	Date of birth of student	☐ Regular Senior Student ☐ Clinical Postgraduate Trainee

2. Malpractice Insurance

You must provide evidence of malpractice insurance for the clinical postgraduate trainee, the preceptor applicant and the regular senior student. See **WAC 246-808-190**.

Applicant's Initials	Date

☐ Proof of Malpractice Insurance is attached.

3. Proof of Licensure

I certify that I have been licensed as a Washington chiropractic doctor for the last five years. During this time my license has not been suspended, revoked, or otherwise conditioned or restricted.

Applicant's Initials	Date

4. Verification of Approval

I have attached verification of approval to participate in the program by an approved chiropractic college.

Applicant's Initials	Date

5. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative procedures and requirements, WAC 246-12

Chiropractic Laws, RCW 18.25

Chiropractic Rules, WAC 246-808

On-Line

AIDS Training Resources, Reference Page

Chiropractic Quality Assurance Commission, Web Page